Los Angeles County
Contract Provider Transition Project
Electronic Behavioral Health Records

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Presenter:

Larry G. Paulson
Director, Provider Services
Outlook Associates, LLC

QUALIS HEALTH.

OUTLOOK Associates, LLC
A Division of Qualis Health

Agenda

❖ **Introductions**

❖ **Timeline**

❖ **Behavioral Health Workflow**

❖ **IT to support Workflow**

❖ **Practice Management Systems**

❖ **EMR, EHR, PHR, HIT, etc.**

❖ **Implementation Options & Considerations**

❖ **Vendor Considerations**

❖ **Planning & Next Steps**

❖ **Lessons Learned**

❖ **Useful Links**

❖ **Question & Answer**

Presentation Objectives

- **Understand system components and integration that are needed to support business goals and objectives**
- **Methods and tactics for identifying and managing workflow changes in behavioral health settings**
- **Steps for planning, evaluating, selecting and implementing systems based upon workflow requirements**
- **Costs of modernizing and automating operations and clinical practices**
- **Encourage forward progress**

Content

❖ **Content is the opinion of presenter**

❖ **Based on the cumulative training, research & experience**

❖ **Presenter does not represent any software or hardware vendor**

❖ **Nothing included in this presentation is proprietary in nature**

Larry Paulson Bio

Larry began his healthcare experience as a clinical dietitian. He has over 32 years of experience in healthcare with over 25 of those years in healthcare information systems. He as a solid history of successfully developing and implementing IT solutions that enhance clinical and business processes of healthcare organizations. He has an in-depth knowledge of clinical information systems and leading healthcare systems vendors.

Outlook Associates/Qualis Health

❖ **Outlook Associates is national healthcare consulting firm**
  ➢ Founded in 1991
  ➢ Headquartered in Tustin, CA
  ➢ Founding goal
    ▪ Improve healthcare in the United States through:
      – The effective use of systems and technology
      – The availability of reliable data on which to base sound medical and business decisions
  ➢ Commitment to California
    ▪ Lead consultant for LAC DMH IBHIS project. Drafting specifications, assisting in vendor selection and assist with implementation
    ▪ Assisting other state entities and agencies in preparation for MHSA
    ▪ A leader in regional health information organizations (RHIOs) and health information exchange (HIE) projects (including Santa Barbara and Long Beach)
  ➢ Commitment to Safety Net Providers
    ▪ Significant focus on improving data and processes in Medicaid and community health systems in order to maximize resources in the patient care of underserved and indigent populations
  ➢ Subsidiary of Qualis Health (QIO)
  ➢ Services include:
    ▪ Business Operations Improvement and Support
    ▪ Systems and Technology Planning and Support

Why are we here?

- **LA County Mental Health is implementing an EHR (Integrated Behavioral Health Information System – IBHIS) necessitating the contract providers to transition from the present direct data entry (DDE) for claims to electronic data interchange (EDI) scheduled to go live in July 2009**
- **Industry trends are necessitating this implementation by LA DMH as well as providers**

Industry Trends

❖ **In the physical health world, electronic data exchanges are routine and very much a proven way of doing business**

❖ **Increasing availability of automation to directly support clinicians**

❖ **Capturing service delivery information at the point of service**

❖ **Secure and appropriate electronic exchange of consumer specific health information**

❖ **Secure electronic exchange of transactions related to insurance, claims processing and payments**

❖ **A greater reliance on evidence-based practices**

❖ **Analysis of outcomes data to support continuing quality improvement**

❖ **Progress on standards for an electronic health record for mental health**

❖ **The possibility that an electronic health record will be mandated by 2014 for organizations receiving federal funds**

Healthcare Delivery Challenges

❖ **Medical error, patient safety, quality and cost issues**

  ➢ 1 in 4 prescriptions taken by a patient are not known to the treating physician

  ➢ 1 in 5 lab and x-ray tests ordered because originals could not be found

  ➢ 40% of outpatient prescriptions unnecessary

Healthcare Delivery Challenges

❖ **Medical error, patient safety, quality and cost issues**

➢ Patient data unavailable in 81% of cases in one clinic, with an average of 4 missing items per case

➢ 18% of medical errors are estimated to be due to inadequate availability of patient information

➢ Patients receive only 54% of recommended care

Healthcare Delivery Challenges

❖ **A fractured and "unwired" healthcare system**

➢ Medicare beneficiaries see 1.3 – 13.8 unique providers annually' on average, 6.4 different providers/yr

➢ 90% of the >30B healthcare transactions in the US every year are conducted via mail, fax, or phone

Institute of Medicine (IOM) Recommended 21st Century Health Care System

❖ **Safe – Avoids Error**

❖ **Effective – Evidence-based**

❖ **Patient-centered**

❖ **Timely – Reduces waits and harmful delays**

❖ **Efficient – Avoids waste**

❖ **Equitable – Provides quality of care unrelated to age, race, gender, geographic location, or socio-economic status**
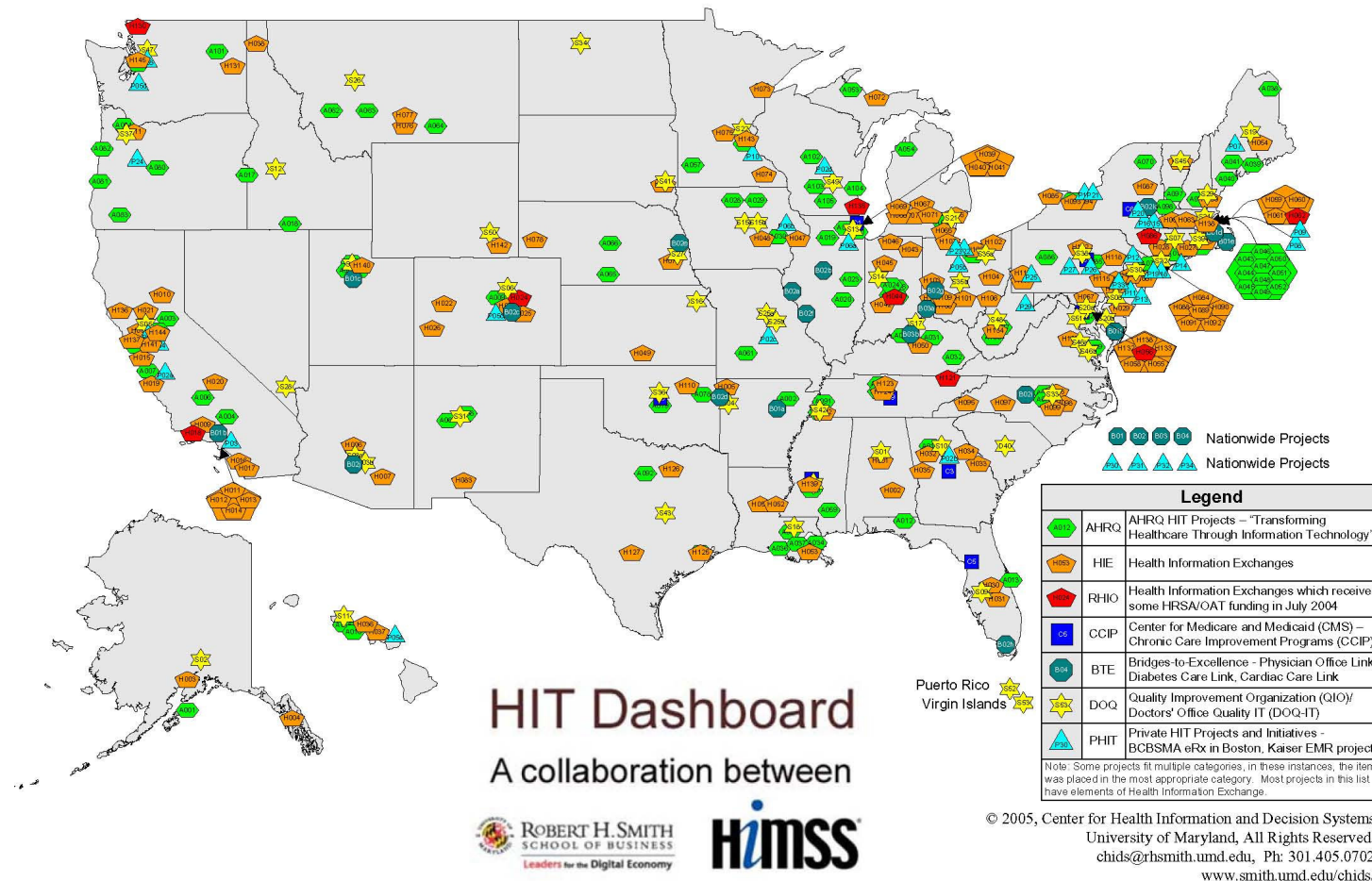
National Timeline

- ❖ **1980s – HIT gets some visibility but most projects fail due in large part to technology barriers**

- ❖ **1990s – Technology sees serious advances – costs for hardware plummet**

- ❖ **Late 1990s – Healthcare quality & cost issues escalate at political levels; HIT begins getting more visibility**

- ❖ **1998 – The Santa Barbara Exchange (RHIO) project starts as a demonstration of *"can the Internet be safely used to exchange healthcare data?"***

- ❖ **Early 2000s – Healthcare quality & cost issues are in the political environment at all time highs**

National Timeline - continued

❖ **April 2004 – President Bush issues Executive Order calling for "most Americans to have access to interoperable electronic medical records by 2014."**

❖ **August 2004 – HHS Secretary Tommy Thompson creates ONCHIT in response to the Executive Order:**
  ➢ Names Dr. David Brailer as National Coordinator (now Dr. Robert Kolodner)
  ➢ Dr. Brailer was the chief investigator on the Santa Barbara project

❖ **2004 – 2006 ONCHIT makes significant progress creating the "Common Framework" and various roadmaps**

❖ **January 2006, "We will make wider use of electronic records and other health information technology to help control costs and reduce dangerous medical errors." – President Bush**

❖ **2004 – 2007 Federal and state grants in many forms are approved to accomplish the goals**

❖ **More than 500 active HIEs in the United States**

❖ **See hhs.gov/healthit for detailed ONCHIT information**

State and Regional HIT Initiatives

HIT Activity in the USA as of August 2005

HIT Dashboard
A collaboration between

ROBERT H. SMITH
SCHOOL OF BUSINESS
Leaders for the Digital Economy

HiMSS

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University of Maryland, All Rights Reserved.
chids@rhsmith.umd.edu, Ph: 301.405.0702
www.smith.umd.edu/chids/

More Acronyms…

❖ **EDI – electronic data interchange**

➢ The activity of electronically exchanging specific data elements between businesses to improve a variety of processes

❖ **HIPAA – Health Insurance Portability and Accountability Act of 1996**

➢ Originally designed surrounding consumer health insurance issues

➢ In part, it encourages the widespread implementation of EDI as a result of the creation of security and privacy requirements

➢ Mandates, in some cases, what EDI standards may be used

And More…

- ❖ **PHI – personal health information**
  - ➢ This is the category of data protected under HIPAA
- ❖ **EMR – electronic medical record**
  - ➢ Lower level of detail; sometimes physician- or disease-specific
- ❖ **EHR – electronic health record**
  - ➢ Generally an aggregate of multiple EMRs, or an "enterprise" deployment of an EMR
  - ➢ Sometimes in the same sentence with "community networks"
  - ➢ Almost always implies the existence of a "network"
- ❖ **PMS – practice management system**
  - ➢ Geared toward the operational aspects of offices that see patients
  - ➢ May sometimes act as an EMR-*Lite*
  - ➢ Historically, they have handled claims – but not necessarily electronically
  - ➢ Historically weaker on the clinical side
- ❖ **PHR – patient health record**
  - ➢ Similar to EHR, but initiated and/or maintained by the patient

And more still…

❖ **ANSI – American National Standards Institute**
  ➢ The accrediting and governing standards organization in the US

❖ **X12 – The "X12" doesn't really mean anything**
  ➢ Refers in general to the officially-governed set of standards used in the United States for EDI
  ➢ Note that X12 is separate from HL7 and other standards

❖ **HL7 – Health Level 7, Inc. – a not-for-profit standards corporation**
  ➢ Generally speaking, a "set" of record formats or standards designed around the exchange of clinical or health data

❖ **NCPDP – National Council for Prescription Drug Programs**
  ➢ Maintains the standards for pharmacy claims

❖ **FTP – File Transfer Protocol**
  ➢ Used here to refer in general to the variety of technologies and protocols used to transfer information over the internet

❖ **XML – Extensible Markup Language**
  ➢ A way of packaging multiple types of standard record sets to be transmitted all together as one package ("wrapping")
  ➢ Could include an X12 837 record, an HL7 record, an x-ray, and an interpretive report all related to one patient

Anticipated IBHIS Functionality

Anticipated IBHIS Functionality

DMH as Provider	DMH as Administrator
• Contact Tracking • Information & Referral Reference • Client Registration • Assessment Management • Financial Screening • Benefits Determination • Appointment Management • Resource Schedule Maintenance • Treatment/Care Plan Management • Clinical Workflow Reminders • Progress Notes Management • Service Capture • Caseload Management • Medication Management • Order Communication • Pharmacy Inventory Management • Billing & Accounts Receivable Management • Field Operations Support	• Call Center Tracking • Information & Referral Maintenance • Eligibility Management • Credentialing • Provider Network Management • Program Management • Protocol/Rules Administration • Claims Processing • Authorization Management • Financial Management • Master Client Index • Formulary Management

Large Multi-Site Provider Functionality

Anticipated IBHIS Functionality

DMH as Provider	DMH as Administrator
• Client Eligibility Verification • Contact Tracking • Information & Referral Reference • **Referral Request Management** • **Client Registration** • **Assessment Management** • Financial Screening • **Benefits Determination** • **Appointment Management** • **Resource Schedule Maintenance** • **Treatment/Care Plan Management** • **Clinical Workflow Reminders** • **Progress Notes Management** • **Service Capture** • **Caseload Management** • **Medication Management** • Order Communication • Pharmacy Inventory Management • **Billing & Accounts Receivable Management** • Field Operations Support	• Call Center Tracking • Information & Referral Maintenance • Eligibility Management • Credentialing • Provider Network Management • Program Management • Protocol/Rules Administration • Claims Processing • Authorization Management • Financial Management • Master Client Index • Formulary Management

Smaller Single-Site Provider Functionality

Anticipated IBHIS Functionality

DMH as Provider	DMH as Administrator
• Contact Tracking	• Call Center Tracking
• Information & Referral Reference	• Information & Referral Maintenance
• **Client Registration**	• Eligibility Management
• **Assessment Management**	• Credentialing
• **Financial Screening**	• Provider Network Management
• Benefits Determination	• Program Management
• **Appointment Management**	• Protocol/Rules Administration
• Resource Schedule Maintenance	• Claims Processing
• **Treatment/Care Plan Management**	• Authorization Management
• Clinical Workflow Reminders	• Financial Management
• **Progress Notes Management**	• Master Client Index
• **Service Capture**	• Formulary Management
• Caseload Management	
• **Medication Management**	
• Order Communication	
• Pharmacy Inventory Management	
• **Billing & Accounts Receivable Management**	
• Field Operations Support	

Technical Infrastructure & Tools

Smaller Organization	Larger/Multi Site Organization	LA County DMH

• Basic Hardware & Operating Systems
• Basic EDI Exchange Capabilities
• Local Area Network
• Report Writer
	• Moderate Hardware & Operating Systems
	• Basic EDI Exchange Capabilities
	• Local & Wide Area Networks
	• Report Writer
		• Large, complex Hardware Platforms & Operating Systems
		• Server Farm
		• Local & Wide Area Networks
		• County Infrastructure Integration
		• Strong EDI Infrastructure
		• Data Warehousing
		• ETL Tools
		• Decision Support Tools
		• Report Writers
		• Web Portals
		  ○ Provider
		  ○ Client
		  ○ County

So what!

Strategies

❖ **Don't do anything – it's gonna be painful**
❖ **Do the minimum to get by:**
  ➢ Maintain what you already have
  ➢ Outsource IT (including EDI processes) if/when possible
  ➢ Invest but only as a last resort
  ➢ In the long-run, this strategy may be painful and expensive
❖ **Develop relationships and/or partnerships**
  ➢ Seek out business partners when possible/appropriate to develop solutions
❖ **Develop A Plan That:**
  ➢ Acknowledges short- and long-term business goals and requirements
  ➢ Identifies current opportunities and/or deficiencies
  ➢ Recognizes realistic capacity to invest
  ➢ Establishes demonstrable or measurable returns or benefits
  ➢ Establishes priorities for taking action
  ➢ Accommodates the attitudes, standards, and framework being developed around healthcare

Implementation Options
"No Magic Wands"

- ❖ **DDE (direct data entry) –** *NOT AN OPTION*

- ❖ **A Distributed Computing Model**
  - ➢ Sub Functions are extended out from a main system operated by the primary trading partner (DMH)
  - ➢ *NOT AN OPTION* – *due to a variety of issues including of cost, legal, procurement, and support*

- ❖ **Your own EMR, EHR or PMS, either separate, interfaced systems or an integrated solution.**
  - ➢ Upgrade your existing system
  - ➢ Install a new system
  - ➢ The best way to control functionality
  - ➢ *Long-term, this is the preferred option for larger, more complex providers with high patient loads and/or complex or custom services*
  - ➢ Positions provider best for long-term HIT

- ❖ **EDI is outsourced to another company (a "clearinghouse")**
  - ➢ Internal systems and processes don't change much
  - ➢ Claims information (probably paper) is turned over to another company that produces the EDI files and interfaces with DMH
  - ➢ Using a clearinghouse in a GPO arrangement may be an option
  - ➢ *Does not work very well for clinical data*
  - ➢ Doesn't position a provider for the long-term of HIT

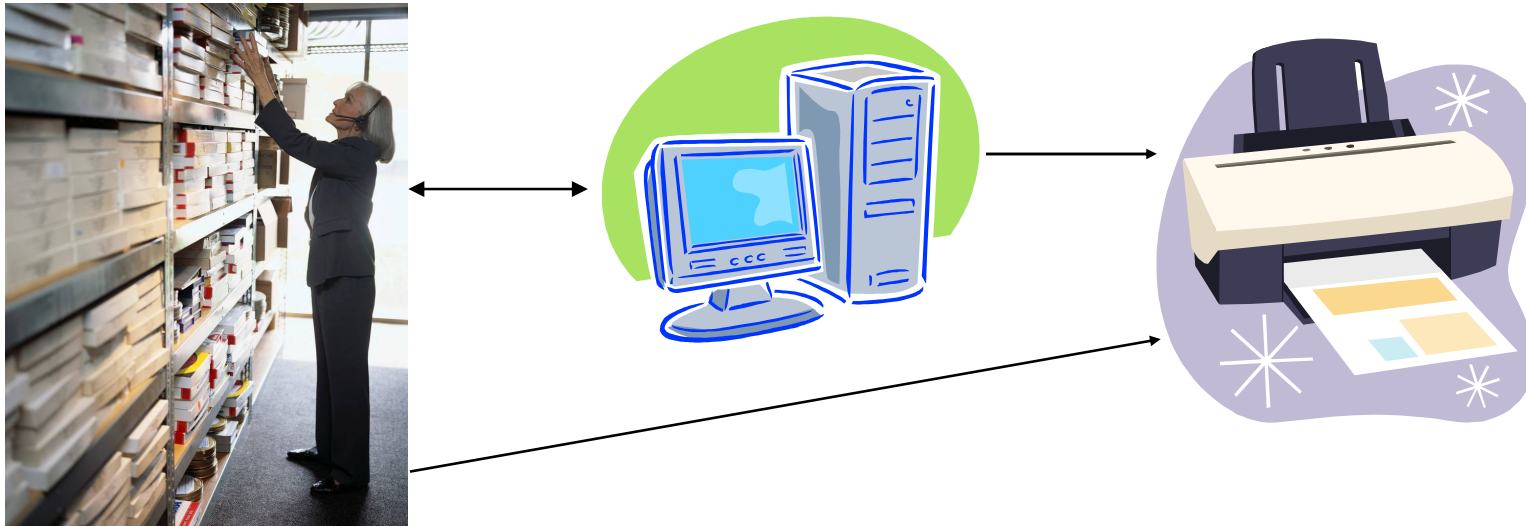# Implementation Options - continued

❖ **Application Service Provider (ASP) Model**
  - ➤ ASP models can be used for claims and/or clinical
  - ➤ May be a good option for practices with 1-5 providers and "manageable" patient loads
  - ➤ *Generally more affordable than implementing your own internal system*
  - ➤ ASPs can be difficult, expensive, or impossible to customize

❖ **TSO Model (Technical Services Organization)**
  - ➤ An organization by and for it's members (usually)
  - ➤ Provides IT and/or IT GPO services
  - ➤ *Can bring more technology options to the table – such as open source systems (OSS) – which may help reduce overall costs*
  - ➤ A TSO could provide EDI/EMR/EHR solutions to its members in a traditional client-server configuration
  - ➤ A TSO could also provide EDI/EMR/EHR solutions using an ASP configuration

Traditional Relationship

Practice Management
- Registration
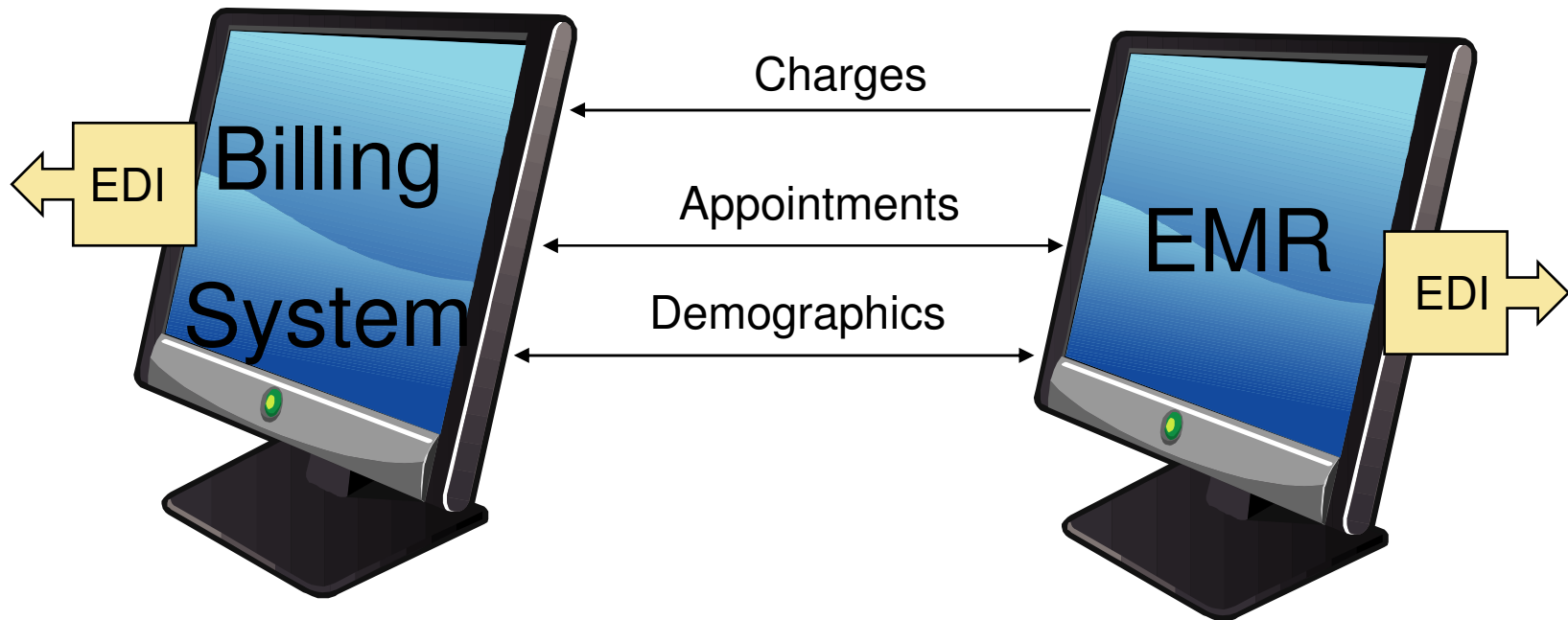- Scheduling
- Billing
- Minimal Clinical

EMR/EHR
- Clinical Documentation
- Lab
- Pharmacy
- Rules
- Controlled Medical Vocabulary

Clinical Repository (data warehouse)
- Pay for Performance
- Quality Outcomes
- Population Management

PM – EMR interface

Billing System — EDI

Charges

Appointments

Demographics

EMR — EDI

EMR vs. EHR: Definitions

❖ **EMR: An application environment composed of the clinical data repository, clinical decision support, controlled medical vocabulary, order entry, computerized provider order entry, pharmacy, and clinical documentation applications. This environment support the patient's electronic medical record across inpatient and outpatient environments, and is used by healthcare practitioners to document, monitor, and manage health care delivery within a care delivery organization (CDO). The data in the EMR is the legal record of what happened to the patient during their encounter at the CDO and is owned by the CDO.**

EMR vs EHR: Definitions

❖ **EHR**: A subset of each care delivery organization's EMR, presently assumed to be summaries like ASTM's Continuity of Care Record (CCR) or HL-7s Continuity Care Document (CCD, is owned by the patient and has patient input and access that spans episodes of care across multiple CDOs with a community, region, or state. The EHR in the US will ride on the proposed National Health Information Network (NHIN).

Difference between EMR & EHR
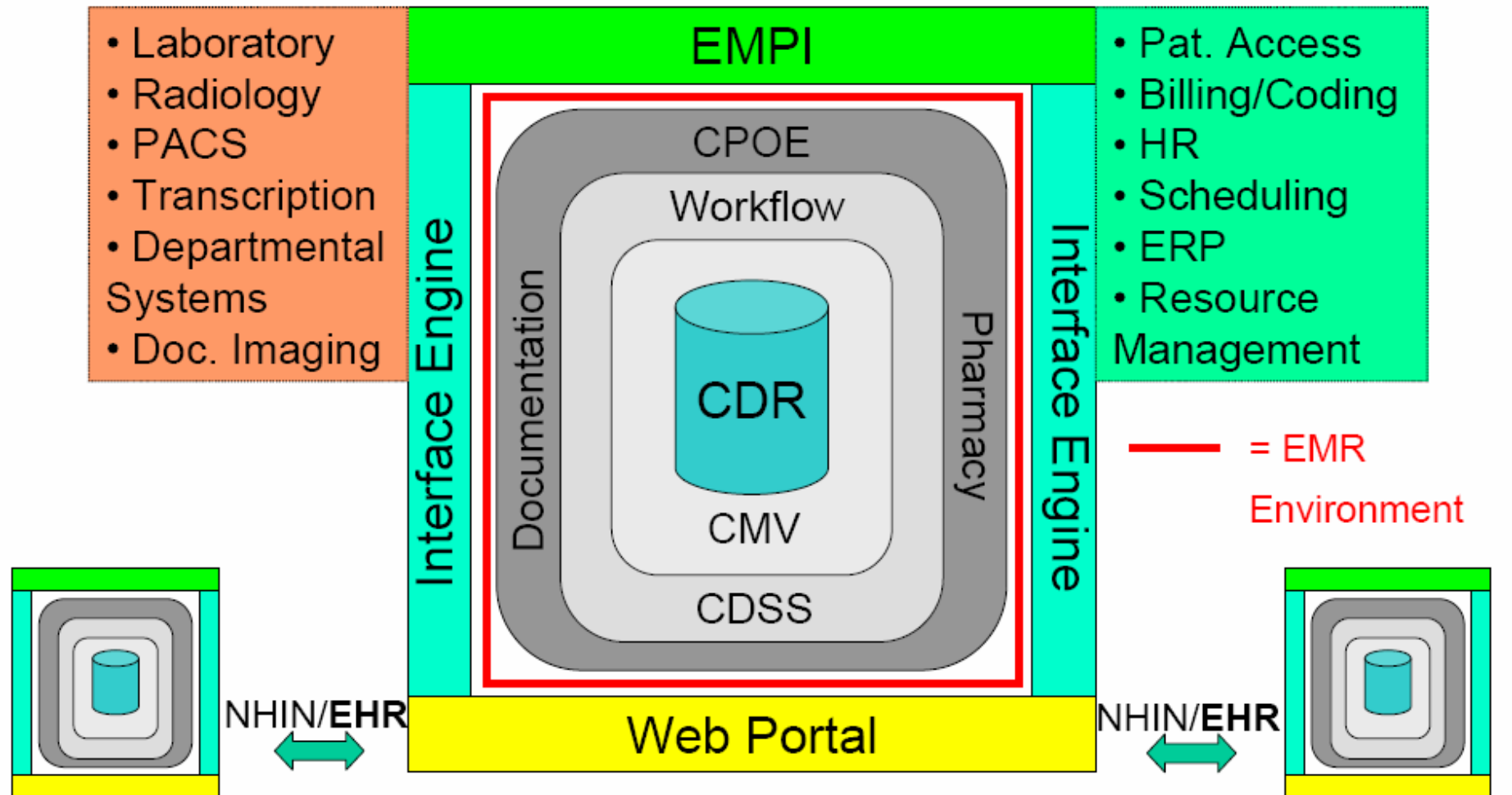
Electronic Medical Records

- The legal record of the CDO
- A record of clinical services for patient encounters in a CDO
- Owned by the CDO
- These systems are being sold by enterprise vendors and installed by hospitals, health systems, clinics, etc.
- May have patient access to some results info through a portal – but is not interactive
- Does not contain other CDO encounter information

Electronic Health Records

- Subset (i.e. CCR or CCD) of information from various CDOs where patient has had encounters
- Owned by patient or stakeholder
- Community, state, or regional emergence today (RHIOs) - or nationwide in the future
- Provides interactive patient access as well as the ability for the patient to append information.
- Connected by NHIN

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EMR and EHR Environments

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Key Elements of the EMR IOM Report 1997

❖ **Clinical Data Dictionary – standards based**

❖ **Clinical Data Repository**

❖ **Point of care facility**

❖ **Ergonomic data entry and data presentation**

❖ **Anticipation of clinical processes**

❖ **Support of multimedia data**

❖ **Interfaces with other HIS components**

Necessary steps for implementing EMR

- ❖ **A thorough analysis of clinical workflow**
- ❖ **Define the problems we are trying to solve and why?**
- ❖ **From day one treat clinician-users as knowledgeable partners**
- ❖ **Anticipate the impact of EMR components on the workflow**
- ❖ **Identify how the EMR will enhance the ability to deliver better care**
- ❖ **Clearly define a long term budgetary plan for EMR**
- ❖ **Ensure that administration is firmly on board**
- ❖ **Understand the limitations of current technology – know when to STOP!**

EMR Adoption Model

		% of US Hospitals
Stage 7	Medical record fully electronic; CDO able to contribute to EHR as byproduct of EMR	0.0%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full PACS	0.1%
Stage 5	Closed loop medication administration	0.5%
Stage 4	CPOE, CDSS (clinical protocols)	1.9%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	8.1%
Stage 2	CDR, CMV, CDSS inference engine, may have Document Imaging	49.7%
Stage 1	Ancillaries – Lab, Rad, Pharmacy	20.5%
Stage 0	All Three Ancillaries Not Installed	19.3%

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Importance of the RFP Process

- ❖ **Conserve time and resources by avoiding poorly phrased questions that result in vague or unclear responses**
- ❖ **Give adequate considerations to stakeholder and end user needs**
- ❖ **Ensure products and services include required features**
- ❖ **Advance more fully integrated products and services**
- ❖ **Promote improved workflow supporting patient satisfaction**
- ❖ **Ensure products and services meet anticipated organizational growth**

AHIMA (American Health Information Management Association)

❖ **The RFP Process for EHR Systems**

➢ http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_034252.hcsp?dDocName=bok1_034252

Criteria for first software purchase vice subsequent

Rank	Initial Purchase Criteria	Subsequent Purchase Criteria
1	Price	Support
2	Ease of Implementation	Vendor
3	Ease of use	Equipment
4	Software fit	Growth
5	Functionality	Software fit
6	Equipment	Documentation
7	Growth	Functionality
8	Support	Ease of implementation
9	Documentation	Ease of use
10	Vendor	Price

Rethinking the Behavioral Health Organization, by Ronald L. Ravensberg, 2005 by Health Systems Computing

Vendor Characteristics

❖ **Reputation and history (e.g. longevity)**

❖ **Ability to provide a list of current customers and references**

❖ **Percentage of research and development reinvested into the company**

❖ **Lifetime of EHR system products (i.e., the occurrence of software obsolescence)**

❖ **Frequency of software updates**

❖ **Customer support availability**

❖ **CCHIT certification status**

Vendor Considerations

❖ **First, establish a clear understanding of what EDI your existing system(s) are capable of:**

➢ Ask your vendor

➢ Call your vendor's other clients

➢ Make site visits to other providers using the same system

➢ Get involved in the detail

➢ *Form a small "user's group" to share information*

❖ **Many vendors use the term "interface" interchangeably with EDI**

Vendor Considerations - continued

❖ **New versus Legacy**

➢ Legacy and/or all older systems – extra caution is required.

- Many of these systems were developed prior to the recent advancements of EDI standards and internet technologies

- Upgrading these systems may be difficult and expensive

- It's crucial to verify all references and all vendors as going-concerns

➢ Most newly or recently developed EMRs, EHRs, PMSs by companies with a strong client-base will support all of the EDI functions that are likely to be required

- If you already have a system, EDI may not have been included, but is likely available

- EDI may be an add-on cost

- All references should be verified

Average Five Year Cost of ASP model

Cost of Ambulatory EHR Implementation in MA (ASP Model)		
Adapted from Partners Health Care System EMR Implementation [1]		
Software annual license	$3,500	Increased from $1,600 to $3,500 based on thought leader input and expected private vendor costs
Implementation	$3,400	Includes workflow redesign, training, and historical chart abstracting
Support and Maintenance	$1,500	Ongoing yearly cost
Hardware (3computers+network)	$6,600	Assumption: hardware replacement every 3 years
Temporary productivity loss	$22,400	Increased from $11,200. Many thought leaders agree that productivity losses are more likely to be seen for 6-months or greater. (Assumes 20% loss in months 1+2, 10% for months 3+4, and 5% for months 5+6)
Total Adjusted Present Value of the 5 year Cost per Physician in MA		$64,215

AAFP EHR Pilot Project

Average Total Cost for first 3 years of ownership based on a 3-physician practice

	Total Cost	Yearly Cost per physician (over 3 years)
Integrated EHR & PMS	$68,371	$7,597
Stand-Alone EHR	$51,714	$5,746
Stand-Alone PMS	$40,274	$4,475

Source: AAFP/CHiT Partners for Patients Vendor Survey, March 2005 http://www.centerforhit.org/x983.xml

Mental Health Software Vendors

Top 25 visited links
Billing Software
Rank: 1st Qtr 2007 (Prv Qtr)

1. TheraManager (1)
2. Confidant Software (2)
3. Office Therapy (4)
4. Practice Magic Software (6)
5. The Therapist (9)

6. Therapist Helper 8)
7. InstaClaim (11)
8. ShrinkRapt (7)
9. PM/2 (12)
10. QuickPractice (14)

11. Delphi/PBS (13)
12. PMA-2000 (16)
13. EZClaim (3)
14. MediSoft (20)
15. SumTime (18)

16. Office Manager (22)
17. TherapySoft
18. Lytec Mental Health Billing (19)
19. MPMsoft
20. MedGoal/MedAssist

www.assessmentpsychology.com/practicesoftware.htm

Implementation Considerations

❖ **Achieve confidence that you are clear about your trading partner(s) specific requirements before investing**

❖ **There are a variety of possible solution "roadmaps", but they depend on your circumstances**

❖ **Coordinate & consult with LAC DMH – an incremental approach to the various EDI transactions may be possible**

❖ **Claims-side EDI may be implemented independently of clinical-side EDI, if necessary**

❖ **It might be possible to comply with EDI claims requirements without having to address clinical EDI issues at the same time (depending on your situation)**

Implementation Considerations - continued

❖ **Depending on your particular circumstances, you might** *as an example*:

  ➢ Use your existing program to fulfill EDI for claims by having your current vendor write a custom interface

  ➢ Or, if you have a small number of claims, you might outsource those to a clearinghouse

  ➢ At the same time, use a simple, inexpensive ASP to collect and centralize patient demographic and clinical information for later EDI purposes. The ASP could handle clinical EDI for a short time if necessary (the ASP would interface to DMH)

  ➢ Meet these short-term requirements while you separately develop a longer-term more structured HIT plan

  ➢ Down the road, you may be able to upload all of the data you have in your ASP into an internal system (or TSO system)

❖ **You may be able to:**

  ➢ Partner with a small number of providers who have similar needs, issues and constraints

❖ **It's crucial to:**

  ➢ Set priorities
  ➢ Not plan "too big"
  ➢ Not do things now that will put you at a disadvantage in the future

Planning & Next Steps

- ❖ **Educate internally**
- ❖ **Designate an EDI subject matter expert:**
  - ➢ Start documenting your operations & identifying options
- ❖ **Read & Learn**
- ❖ **Coordinate with DMH**
- ❖ **Get involved, attend all of the meetings**
- ❖ **Ask questions – ask the same question more than once**
- ❖ **Develop an overall, long-term IT plan**
- ❖ **Hire a consultant if it will help, but:**
  - ➢ Most consultants don't write software
  - ➢ Hire a consultant with a background that includes healthcare business & clinical operations *AND* IT expertise – one without the other is less desirable
  - ➢ Verify references

Lessons Learned

❖ **Hire or designate a full-time Project Manager *for any large IT initiative***

❖ **Set goals & priorities for your day and week and focus on those – you won't be able to resolve all of the issues overnight**

❖ **Take ownership today**

❖ **Don't ask the vendor to take ownership**

❖ **Don't procrastinate. Depending on your options, the elapsed time to a solution could be several months or longer**

❖ **This issue may be time-intensive if there is a learning curve**

❖ **Depending on your IT situation, don't over book whoever is handling EDI**

❖ **You might have to hire someone *(but not an IT staff)* to deal with this – do so if it's necessary; it's better than the alternative**

❖ **Peer review is essential – get a 2nd and 3rd opinion before committing**

❖ **Contact an academic institution to learn about their intern programs**

Conclusions

❖ **Do not get caught up in the hype: The basic barriers to implementing EMRs (effort, business appropriateness, and cost) are still valid.**

❖ **It is optimal to implement the system incrementally by increasing functionality as physicians are able to handle it. Web-based components, or directed implementation of an EMR via an ASP, may help facilitate this.**

❖ **Make sure your systems approach addresses the needs of your providers and patients.**

❖ **Think of EMR implementation as organizational transformations rather than "plug-and-play" software implementation in order to maximize benefit.**

❖ **Security will be a consideration regardless of approach selected. Plan accordingly,**

After all these years . . .

- ❖ **Implementing a successful EMR is very difficult**
- ❖ **When properly implemented, computer-based decision support work**
- ❖ **Clinicians embrace new technology – _IF_ it improves on existing systems**
- ❖ **Patients are generally positive about the use of IT in their care**
- ❖ **National standards are important contributors to success**

Useful Links

- ❖ **WIKIPEDIA.COM**
- ❖ **ANSI.ORG**
- ❖ **X12.ORG**
- ❖ **HL7.ORG**
- ❖ **SOURCEFORGE.NET (Open source system index)**
- ❖ **HHS.GOV/HEALTHIT**
- ❖ **NCPDPD.ORG**
- ❖ **XML.ORG**

Discussion

For more information:

Larry Paulson, Director of Provider Services
lpaulson@outlook-associates.com

Patrick Gauthier, Director of Business Development
pgauthier@outlook-associates.com

Outlook Associates, LLC
714-689-9986
www.outlook-associates.com

Contract Provider Transition Project
cptt@lacdmh.org

Certification Commission for Healthcare Information Technology (CCHIT)

❖ **CCHIT is the recognized certification authority in the United States for EHR products – an independent private sector organization that sets the gold standard for EHRs.**

CCHIT Certified

❖ **A CCHIT Certified seal assures clinician that an EHR product meets basic requirements for:**
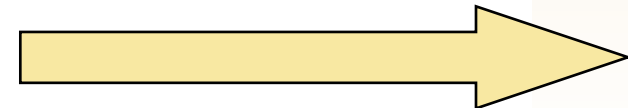
➢ Functionality (ability to carry out certain tasks)

➢ Interoperability (compatibility with other products) and

➢ Security (ability to keep your patient information safe)

Look for the label

Certification Commission for Healthcare
Information Technology   www.cchit.org

But for Behavioral Health

CCHIT and Behavioral Health

On its website home page (www.cchit.org), CCHIT clarifies the scope and limitations of its recently developed certification criteria as:

> *The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of significance for specialties and domains not yet addressed by CCHIT Criteria.*